At What Cost: Price and Common Procedures in Ohio’s Hospitals

By: Loren Anthes
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August 24, 2020
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BACKGROUND

While the United States spends more than other industrialized nations on health care, its outcomes lag. The United States spends the most on hospitals in terms of health spending, followed by physicians and clinics, half of which are owned or affiliated with a hospital. Looking at the $3.6 trillion the U.S. spends, in total, this means nearly $1 trillion flows through hospital systems. The economic impact of hospitals, both in terms of spending and employment are profound, with hospitals accounting for more than 5 million jobs and nearly $350 billion in wages. Costs are frequently cited by the industry in regards to this outsized economic role, making an examination of the inputs tied to those costs a worthy exercise. Socioeconomics and differences in social welfare programming certainly explains some of the differences in spending when compared to other industrialized nations. However, the evidence suggests price, and the deregulated environment in which that price is established, is the driving force behind the difference in spending between the United States and other nations. This paper endeavors to examine these issues, by reviewing prices set by Ohio hospitals in their chargemasters and compares those prices to national and international data for a set of commonly performed procedures. What is represented here is based on available chargemaster data collected in early 2020 and does not represent what patients should expect to pay, directly.

KEY TAKEAWAYS

- As the largest cost center in national health expenditures, hospitals receive nearly 1 in 3 dollars spent on U.S health care, and much of this spending is fueled by the prices individual hospitals or providers set.
- Patient choices regarding where they purchase medical services do not seem to be influenced by price but rather by other factors
- Prices for common procedures vary greatly and are not readily available or in a plain language format, and while they can be differentiated by hospital type and business model, there is no consistent relationship between these factors and price
- The State of Ohio should develop sound, cost-effective policies that can create a more competitive marketplace, and ensure that data regarding price, quality and regulatory capture is monitored, made public where feasible and leveraged for reform
INTRODUCTION

The United States (U.S.) spends nearly twice as much as other average industrialized nations on health care as a share of its economy (16.9 percent of gross domestic product or GDP). In fact, since 1970, health care’s average annual spending growth has outpaced the growth of the U.S. economy, generally. Despite this investment, the United States covers fewer of its citizens, has the lowest life expectancy of other industrialized nations and some of the highest rates of chronic disease burden, obesity and hospitalizations from preventable causes.

When looking at the root causes in the differences in health spending, research suggests that the prices are the primary reason the U.S. spends more than any other nation. Looking into some of the data that supports this conclusion, the U.S. delivery system has less access to generalist physicians, more of its hospital beds are allocated for acute care, it more often employs costly diagnostic and treatment technology (e.g., magnetic resonance imaging or MRI), pays the highest salaries to clinicians and reimburses pharmaceutical companies at much higher rates than peer nations. It is also key to point out that government often plays an outsized role in other nations, while the majority of insurance coverage in the U.S. is private. This means the U.S. system theoretically relies on marketplace principles to drive better outcomes at a lower cost. However, evidence would suggest that is not happening.

In healthy marketplaces, consumers, empowered with clear, understandable information regarding price and outcomes, would be able to comparison shop. As rational actors, individuals seeking out a good or service would assign value to the goods they are seeking, and choose which goods to buy based on the information available to them. This is why some have supported the notion of increased price transparency in health care. If patients were only empowered with the information necessary to make informed decisions, as the theory goes, the marketplace would naturally stabilize and prices would fall. But evidence shows that price transparency in health care does not, drive down prices or substantially influence individual consumption patterns. In fact, research suggests that patients are “predictably irrational,” meaning the choices patients make about services and where to receive them are often not based on complex evaluations of available information and data, including price. Therefore, examining

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1 “Industrialized nation” refers to Organisation for Economic Co-operation and Development (OECD) member countries. Nations included in this analysis are limited to those OECD members for whom comparison information on diagnosis-related group was available.


the policy concept of price transparency, and how it is implemented today, can inform other, more impactful policy approaches.  

**CURRENT STATE**

In June 2019, President Donald Trump signed an executive order to fully implement the Affordable Care Act’s Section 2718(e) of the Public Health Service Act. This action built on previous guidance that required hospitals to make their standard charges public. These standard charges are aggregated into a file that is known as a “chargemaster” that summarizes the prices hospitals set for services. Often, hospitals set their chargemaster prices intentionally higher than the actual costs of care, with a recent study showing the average U.S. hospital charges 4.3 times the actual cost of a good or service (often called the cost-to-charge ratio). It is with this in mind that the transparency rule was developed, to encourage greater competition through greater awareness of these prices, provider to provider.

The requirement mandates each hospital operating within the United States establish, update and make public their chargemaster in an online, machine-readable format. This would include prices for all items and services with a standard charge that are used in connection with a visit or admission to the hospital. The chargemaster has to be displayed in a “consumer-friendly” manner, meaning the service must be in plain language, must be prominently available online and clearly identify the location where the service was performed. Hospitals have until January 2021 to comply with this rule.

As the largest cost center in national health expenditures, hospitals receive nearly 1 in 3 dollars spent in the U.S. However, hospitals have historically fought against transparency regulations in the courts, and a number of hospital-affiliated trade associations are currently appealing a June decision that upholds the regulation. And while hospitals are not yet required to follow this rule, as it will not be fully enforced until 2021, many hospitals do already publish their chargemasters online.

The goal of this paper is to examine the publicly available chargemaster information in Ohio and compare it to national and international data regarding price. To do this, data was sought from Ohio’s 206 hospitals online, and by making calls when none of the data was readily available. Not all available data may be captured in this analysis, and hospitals are listed anonymously. Data from the Health Care

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6 Gilbert Benavidez, “Price Transparency in Health Care Has Been Disappointing, but It Doesn't Have to Be,” JAMA (American Medical Association, October 1, 2019), [https://jamanetwork.com/journals/jama/fullarticle/2752049](https://jamanetwork.com/journals/jama/fullarticle/2752049).
Cost Institute is used for international and national price information, and comparisons are made for the following procedures:  

1) Inpatient Appendectomy  
2) Inpatient Bypass Surgery  
3) Angioplasty  
4) Total Joint Replacement  
5) Cesarean sections  
6) Labor and delivery without induction, complications, etc. (i.e. Normal Delivery)  

The procedures listed were chosen because of how common the services are across institutions and the availability of the data. The procedures were identified by using their diagnosis-related group codes or DRGs. DRGs are a patient classification system that serves as the basis for Medicare reimbursement and categorizes services into homogenous units representing a “product.”

Each of the procedures will be covered in its own section and will contain identical data points including number of reporting hospitals, range of chargemaster price across all hospitals and range of price. Range of price includes two levels of analysis, inclusive of the same hospitals, relative to type of hospital (e.g., rural vs. teaching) and hospital business model (nonprofit v. for profit). This means a single hospital will appear twice in this section.

Classifications of these hospitals were based on their type as listed by the Ohio Hospital Association, the definition of which is self-evident in the classification typology. The author reviewed the multiple classifications and assigned hospitals into the most logical category. For example, if a children’s hospital was listed as a children’s hospital and a teaching hospital, children’s hospital was used given children’s hospitals’ unique licensing requirements. Readers may also note differences between hospital information available for each procedure. Given the nature of the procedures, the frequency with which hospitals perform and report them, not all categories appear in each procedure.

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For the ranges by type of hospital and hospital business model, box plots are used. A box plot organizes the data into quartiles where one quartile represents 25 percent of the available data. The “box” represents the second and third quartiles to show where most hospitals set their prices. Looking at the diagram, this represents all data above the first quartile and below the third quartiles. Median was chosen for this analysis as the mean will be represented in a separate table comparing Ohio’s price to national and international averages. The lines coming out from the boxes show the other quartiles and provide a sense of the total range in price, represented by the difference between the minimum and maximum. For any anomalies or data points which are inconsistent with the data overall, outliers are identified as small circles in the diagram.

It should be reiterated that what is represented here is based on available chargemaster data collected in early 2020 and does not represent what consumers should expect to pay, directly. Finalized payments individuals make to providers and payers are determined on a case-by-case basis, depending on the terms of coverage and what is negotiated between hospitals and insurance companies. It should also be noted that this data does not represent what is paid by Medicaid or Medicare, as those fees are established in regulation. With that said, as the majority of public benefits are also managed by private insurance companies, many of the prices ultimately paid to providers are often higher than what is established by government. Additionally, despite evidence of federal data that suggests Medicaid already covers costs of most hospitals in the U.S., it only pays two-thirds of what Medicare pays.13 Medicare, by comparison, reimburses at rates that are typically half of what the average employer-sponsored plan reimburses.14

INPATIENT APPENDECTOMY: DRG 343

Availability

Of Ohio’s 206 hospitals, 43.69 percent had chargemaster data available for inpatient appendectomy. The rest were either not available, a chargemaster was not provided, they did not perform the procedure or no DRG code was found.

Price Comparison: Ohio, the U.S. and International Averages

<table>
<thead>
<tr>
<th>Country</th>
<th>Average Price</th>
<th>Ratio to US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>$31,669.90</td>
<td>209.0%</td>
</tr>
<tr>
<td>USA</td>
<td>$15,155.00</td>
<td>--</td>
</tr>
<tr>
<td>South Africa</td>
<td>$3,161.10</td>
<td>20.9%</td>
</tr>
<tr>
<td>Holland</td>
<td>$6,020.80</td>
<td>39.7%</td>
</tr>
<tr>
<td>Australia</td>
<td>$4,246.20</td>
<td>28.0%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$6,208.00</td>
<td>41.0%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>$6,714.50</td>
<td>44.3%</td>
</tr>
<tr>
<td>UAE</td>
<td>$4,242.00</td>
<td>28.0%</td>
</tr>
<tr>
<td>UK</td>
<td>$5,097.60</td>
<td>33.6%</td>
</tr>
</tbody>
</table>

Each bar represents one Ohio hospital chargemaster price for the procedure. Prices range from $12,704 to $47,884.

Ohio’s hospital prices are 2.09 times the national average. The national average is 2.25 times more than the next highest priced nation.
Rural hospitals had the lowest median price at $25,811.16 with a $27,935.90 difference between the highest and lowest prices.

Acute care hospitals had a median price of $30,674.00 with a $28,763 difference between the highest and lowest prices.

Teaching hospitals had the highest median price of $33,838 with a $30,035 difference between the highest and lowest prices.

Only one children’s hospital had a procedure listed at $33,838.

Nonprofit hospitals had a median price of $30,280.23 with a $30,472 difference between the highest and lowest prices.

Public hospitals had the lowest median price of $29,852.32 with a $25,599.23 difference between the highest and lowest prices.

Nonprofit hospitals with a religious affiliation had the highest median price of $43,204 and a $23,164 difference between the highest and lowest prices.
INPATIENT BYPASS SURGERY: DRG 234

Availability

Of Ohio’s 206 hospitals, 27.67 percent had chargemaster data available for inpatient bypass surgery. The rest were either not available, a chargemaster was not provided, they did not perform the procedure or no DRG code was found.

Price Comparison: Ohio, the U.S. and International Averages

<table>
<thead>
<tr>
<th>Country</th>
<th>Average Price</th>
<th>Ratio to US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>$187,164.40</td>
<td>239.6%</td>
</tr>
<tr>
<td>USA</td>
<td>78,104.00</td>
<td>--</td>
</tr>
<tr>
<td>South Africa</td>
<td>30,609.80</td>
<td>39.2%</td>
</tr>
<tr>
<td>Holland</td>
<td>11,673.10</td>
<td>14.9%</td>
</tr>
<tr>
<td>Australia</td>
<td>35,800.10</td>
<td>45.8%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>32,010.00</td>
<td>41.0%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>37,772.70</td>
<td>48.4%</td>
</tr>
<tr>
<td>UAE</td>
<td>33,059.30</td>
<td>42.3%</td>
</tr>
<tr>
<td>UK</td>
<td>24,440.40</td>
<td>31.3%</td>
</tr>
</tbody>
</table>

Each bar represents one Ohio hospital chargemaster price for the procedure. Prices range from $13,024.07 to $288,182.

Ohio’s hospital prices are 2.4 times the national average. And the national average is 2.06 times more than the next highest priced nation.
Price Comparison: Dispersion Based on Hospital Type

- Rural hospitals had the lowest median price at $111,491.42 with a $218,150 difference between the highest and lowest prices for the procedure. Only three rural hospitals performed the procedure.
- Teaching care hospitals had the highest median price of $185,714.15 with a $196,658 difference between the highest and lowest prices.
- Acute care hospitals had a median price of $176,759.48 with a $172,999 difference between the highest and lowest prices.
- Only one children’s hospital had a procedure listed at $196,595.

- Public hospitals had a median price of $176,759.48 with a $220,425.93 difference between the highest and lowest prices. Few public hospitals reported performing the procedure, with the one that did serving as outlier at $13,024.07.
- Nonprofit hospitals with religious affiliations had the lowest median price of $179,347 and a $172,817 difference between the highest and lowest prices. One hospital stood as an outlier, pricing the procedure at $288,007.
- Nonprofit hospitals had a median price of $196,595 with a $196,833 difference between the highest and lowest prices.
ANGIOPLASTY: DRG 247

Availability

Of Ohio’s 206 hospitals, 37.38 percent had chargemaster data available for angioplasty. The rest either did not have data available, a chargemaster was not provided, they did not perform the procedure or no DRG code was found.

Price Comparison: Ohio, the U.S. and International Averages

Each bar represents one Ohio hospital chargemaster price for the procedure. Prices range from $9,687 to $117,760.

Ohio’s hospital prices are 2.23 times the national average. The national average is 1.95 times the next highest priced nation.

<table>
<thead>
<tr>
<th>Country</th>
<th>Average Price</th>
<th>Ratio to US</th>
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<tbody>
<tr>
<td>Ohio</td>
<td>$71,828.29</td>
<td>222.9%</td>
</tr>
<tr>
<td>USA</td>
<td>$32,229.00</td>
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</tr>
<tr>
<td>South Africa</td>
<td>$9,034.80</td>
<td>28.0%</td>
</tr>
<tr>
<td>Holland</td>
<td>$6,385.80</td>
<td>19.8%</td>
</tr>
<tr>
<td>Australia</td>
<td>$14,667.00</td>
<td>45.5%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$7,372.00</td>
<td>22.9%</td>
</tr>
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<td>New Zealand</td>
<td>$16,493.30</td>
<td>51.2%</td>
</tr>
<tr>
<td>UAE</td>
<td>$11,861.00</td>
<td>36.8%</td>
</tr>
<tr>
<td>UK</td>
<td>$11,661.30</td>
<td>36.2%</td>
</tr>
</tbody>
</table>
Price Comparison: Dispersion Based on Hospital Type

- Rural hospitals had the lowest median price at $62,237.60 with a $36,527 difference between the highest and lowest prices for the procedure.
- Teaching care hospitals had a median price of $67,521.80 with a $88,460 difference between the highest and lowest prices.
- Acute care hospitals had the highest median price of $68,827.30 with a $53,702 difference between the highest and lowest prices.
- Only one children’s hospital had a procedure listed at $91,472.

- Nonprofit hospitals had the highest median price of $69,478.50 with a $108,073 difference between the highest and lowest prices for the procedure.
- One hospital stood as an outlier, pricing the procedure at $9,687.
- Nonprofit hospitals with religious affiliations had the lowest median price of $59,949 and a $60,585 difference between the highest and lowest prices for the procedure.
- Public hospitals had the lowest median price of $68,174.55 with a range of $45,356.74. One hospital stood as an outlier, pricing the procedure at $96,909.
Of Ohio’s 206 hospitals, 54.85 percent had chargemaster data available for joint replacement. The rest either did not have the information available, a chargemaster was not provided, they did not perform the procedure or no DRG code was found. International data was stratified by knee and hip replacement, so averages for Ohio data were used. Prices were comparable for purposes of analysis.

<table>
<thead>
<tr>
<th>Country</th>
<th>Average Price</th>
<th>Ratio to US</th>
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<tbody>
<tr>
<td>Ohio</td>
<td>$52,750.79</td>
<td>178.3%</td>
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<tr>
<td>USA</td>
<td>$31,053.50</td>
<td>--</td>
</tr>
<tr>
<td>South Africa</td>
<td>$10,478.85</td>
<td>33.7%</td>
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<tr>
<td>Holland</td>
<td>$7,224.05</td>
<td>23.3%</td>
</tr>
<tr>
<td>Australia</td>
<td>$19,745.50</td>
<td>63.6%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$16,975.00</td>
<td>54.7%</td>
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<tr>
<td>New Zealand</td>
<td>$17,121.30</td>
<td>55.1%</td>
</tr>
<tr>
<td>UAE</td>
<td>$21,705.40</td>
<td>69.9%</td>
</tr>
<tr>
<td>UK</td>
<td>$12,417.35</td>
<td>40.0%</td>
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</table>

Each bar represents one Ohio hospital chargemaster price for the procedure. Prices range from $27,269 to $111,870.

Ohio’s hospital prices are 1.78 times the national average. The national average is 1.43 times the next highest priced nation.
• Rural hospitals had the lowest median price at $42,818.10 with a $66,005 difference between the highest and lowest prices for the procedure.
• Acute-care hospitals had a median price of $45,645 with a $77,101.71 difference between the highest and lowest prices for the procedure.
• Teaching hospitals had the highest median price of $55,928 with a $48,458 difference between the highest and lowest prices for the procedure.
• Only one children’s hospital had the procedure listed at $58,937.

• Nonprofit hospitals had a median price of $43,054.23 with a $68,269 difference between the highest and lowest prices for the procedure.
• One hospital stood as an outlier, pricing the procedure at $95,538.
• Nonprofit hospitals with religious affiliations had the highest median price of $68,550 and a $55,468 difference between the highest and lowest prices for the procedure.
• Public hospitals had a median price of $58,543 with a $69,704.31 difference between the highest and lowest prices for the procedure.
• Only one for-profit hospital had a procedure listed at $43,169.
CAESAREAN SECTION: DRG 766, 785, 788

Availability

Of Ohio’s 206 hospitals, 46.10 percent had chargemaster data available for caesarean section. For the rest, a chargemaster was not provided, they did not perform the procedure or no DRG code was found. Coding on the procedure varied by hospital, so three DRGs were used to make the data comparable for analysis purposes.

Price Comparison: Ohio, the U.S. and International Averages

Each bar represents one Ohio hospital chargemaster price for the procedure. Prices range from $5,601 to $45,469.57.

Ohio’s hospital prices are 1.43 times the national average. The national average is 1.79 times the next most expensive nation.
Price Comparison: Dispersion Based on Hospital Type

- Teaching hospitals had a median price of $20,540.50 with a $36,332 difference between the highest and lowest prices for the procedure.
- Acute-care hospitals had the lowest median price of $18,382 with a $28,914 difference between the highest and lowest prices for the procedure and an outlier of $37,788.
- Rural hospitals had a median price at $19,418.64 with a $35,352.22 difference between the highest and lowest prices for the procedure.
- Of the three reporting Veterans Affairs hospitals, there was a $18,726.72 difference between the highest and lowest prices for the procedure.
- Children’s hospitals had a median price of $24,682.99 with a $16,889 difference between the highest and lowest prices for the procedure.

- Nonprofit hospitals had a median price of $18,823.12 with a $39,868.57 difference between the highest and lowest prices for the procedure and one outlier at $45,469.57.
- For-profit hospitals had the lowest median price of $17,893, with a $33,059 difference between the highest and lowest prices for the procedure, with two outliers at $37,788 and $41,933.
- Public hospitals had a median price of $21,452 with a $27,711.76 difference between the highest and lowest prices for the procedure.
- Nonprofit hospitals with religious affiliations had a median price of $22,243.81 and a $21,601 difference between the highest and lowest prices for the procedure and an outlier at $37,788.
NORMAL DELIVERY: DRG 775, 798, 807

Availability

Of Ohio’s 206 hospitals, 55.85 percent had chargemaster data available for a normal delivery. For the rest, a chargemaster was not provided, they did not perform the procedure or no DRG code was to be found. Coding on the procedure varied by hospital, so three DRGs were used to make the data comparable for analysis purposes.

Price Comparison: Ohio, the U.S. and International Averages

Each bar represents one Ohio hospital chargemaster price for the procedure. Prices range from $3,277 to $41,108.

Ohio’s hospital prices are 1.44 times the national average. The national average is 1.24 times more than the next highest priced nation.
• Teaching hospitals had a median price of $17,125 with a $34,535 difference between the highest and lowest prices for the procedure.

• Rural hospitals had the lowest median price at $12,675 with a $32,424.36 difference between the highest and lowest prices for the procedure.

• Acute-care hospitals had a median price of $13,701 with a $21,656 difference between the highest and lowest prices for the procedure.

• Of the three reporting Veterans Affairs hospitals, the difference between the highest and lowest prices for the procedure was $30,900.83.

• Children’s hospitals had the highest median price of $25,799.97 with a $28,582 difference between the highest and lowest prices for the procedure.

• Nonprofit hospitals had a median price of $12,824 with a $37,831 difference between the highest and lowest prices for the procedure and one outlier at $41,108.

• For profit hospitals had the highest median price of $17,094.50 with a $23,602.36 difference between the highest and lowest prices for the procedure.

• Public hospitals had the lowest median price of $8,186 with a $31,999.95 difference between the highest and lowest prices for the procedure.

• Nonprofit hospitals with religious affiliations had a median price of $15,249 and a $29,497.48 difference between the highest and lowest prices for the procedure, and an outlier at $37,812.
CONCLUSIONS AND RECOMMENDATIONS

Given the variation and apparent broad absence of basic, simple chargemaster price information, it is clear that established price has little current direct consumer benefit for Ohio patients. And while this could suggest that improving Ohio’s transparency may be beneficial, the data shows the already published information on price in the state is not changing consumer behavior nor is it affecting chargemaster rates. This is consistent with evidence from the literature on this issue which suggests that most individuals rarely use price information and that transparency is not associated with lower spending. The reasons for this are complex. First, most patients are not direct consumers of the services they receive – they are consumers of insurance which negotiates prices on their behalf. Second, quality of service as determined by patients has little to do with outcomes as much as it has to do with perception. In a recent review of national quality ranking systems, information regarding hospital quality often included conflicting or, unfortunately, inaccurate information on outcomes. This could lead patients to make choices based on information that does not correlate directly with positive medical outcomes. Also, from an equity standpoint, such ranking systems do not traditionally consider the relative risk of the populations being served. As such, hospital rankings typically do not account for the socio-demographics of patients served, which passively encourages disparate delivery systems between populations along the lines of race and economics.

As previously mentioned, while chargemasters are used as the basis of negotiation with third-party payers, and they often do not represent what is ultimately paid by patients or their insurers. The chargemaster allows hospitals to claim higher prices for costs of services more than it reflects the actual expenses hospitals incur while providing these services. In fact, uninsured or self-pay individuals may be liable for the prices identified in the chargemaster, leading many patients to be sent to collections agencies, thus harming credit, or creating debt. Ironically, this also allows hospitals to claim uncompensated care as a part of their cost reporting, which ultimately supports their ability to maintain tax-exempt status and receive supplemental payments from Medicare and Medicaid. And while it is true that some hospitals have more intensive capital needs due to the type of services they provide - particularly hospitals that train physicians or provide the bulk of care for lower-income populations - the range in chargemaster prices suggest that these differences are not organized in a logical or rational manner, even when they are transparent in the marketplace. Yet, this problem is not unique to Ohio and several states have sought reform. The following represents some considerations for Ohio lawmakers as they seek to rein in spending and create more value in the private marketplace.

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15 Ibid., 5
Create an Independent Oversight Entity

In 2012 Massachusetts established a Health Policy Commission (HPC) as an independent government agency to conduct and disseminate in-depth analysis regarding spending, and providing recommendations to change public policy. As a part of this work, the HPC sets a cost benchmark, which in turn sets a statewide target for the growth of total expenditures that is less than the state's average economic growth. This body also has the ability to examine provider transactions and sanction for non-compliance, adopt incentives for alternative payment models, enforce public reporting of prices and quality information and establish a fund to support financially-distressed hospitals. In the context of reviewing spending growth by a provider, this board has the ability to initially review increases without disclosing the review to the public, which protects providers from disclosing proprietary information. In addition, the HPC is able to review and collect data on mergers and acquisitions, certifies Accountable Care Organizations and provides technical support for providers to support reforms. This is all in an effort to encourage greater competition and marketplace diversity.

Ohio should consider replicating the Massachusetts model. Considerations must be adhered to, however, to ensure the commission is truly independent and avoids regulatory capture. For that reason, appointments should be made to avoid overt political influence and business conflicts of interest. In this way, a similar commission should mirror what exists with the Legislative Service Commission, which would enable industry experts to effectively and objectively collect, synthesize and analyze data for policy development. Additionally, the entity could be concurrently created, and responsible for the implementation of legislation regarding financial transparency of hospitals, such as the model legislation proposed by the National Academy for State Health Policy (NASHP).

Reference Based Pricing

In 2018, Montana lawmakers required the state’s Health Care and Benefits division to negotiate lower prices to control increasing costs. The result was a system of reference-based pricing. In this system, as opposed to starting with the hospital’s list price and negotiating down for discounts, the state began telling these facilities how much it was willing to pay for each type of hospitalization using Medicare rates as a baseline. In the end, the state would pay 234 percent of Medicare rates, ultimately saving the state’s insurance plan $15.6 million in 2018. While this model is specifically oriented toward the state, which has the advantage of scale and regulatory power necessary to compel the shift in the marketplace, Ohio could look to such a program as a means to cost contain in its own private insurance program.

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Establish a Basic Health Plan in the Marketplace

The Basic Health Program (BHP), created in the Affordable Care Act (ACA), offers states an alternative to marketplace coverage for certain uninsured individuals with incomes between 133 and 200 percent of the federal poverty level (FPL). Although these individuals would qualify for marketplace tax credits, the ACA included the BHP option to make coverage more affordable for lower-income consumers.23

Historically, many individuals between 138 and 200 percent of the FPL lack coverage.24 Put another way, individuals making between $17,609 and $25,520 do not seem to retain coverage due to expense even after subsidization. A BHP could provide the state the opportunity to develop its own insurance product for this band of income. This product, like in Medicaid, could be contracted out to private plans to leverage market forces and could even have a direct contractual relationship to Ohio’s managed care plans as a continuum. Not only would this provide these insurers the scale to more effectively negotiate price, as more than 3.5 million Ohioans earn less than 200 percent of the FPL, but it would improve the risk profile of insurers that provide coverage for those with incomes above 200 percent FPL in the marketplace and through employer-sponsored products.

Concluding Remarks

This paper is not intended to frame hospitals as bad actors. Instead, it is meant to reflect the systemic spending problems we see as a byproduct of policy development that is agnostic to price and quality. While value-based payments will indeed create market conditions that are more responsive to prevention and upstream solutions, the fact remains that price transparency is not an effective tool to control costs. Simply put, there is no way a consumer can expect to shop for a product with a price that they can’t impact by their actions, nor completely understand in a system of billing and accounting that has more codes than the average American’s vocabulary. Not to mention that when consumers are purchasing various health care procedures and products cost often isn’t the predominant motivation. Instead, the state has a role to play to develop sound, cost-effective policies that can better manage these critical resources in ways that actually increase competition and innovation. Not only will this create a better landscape for employers who want to do business in Ohio, but it will protect consumers who rightfully expect to receive a quality service at a fair price when they need it most.

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